Office-Supreme Court, U.S.
FILED
JUL 2 1981
ALEXANDER L. STEVAS,
CLERK

No. 80-1417

IN THE
# Supreme Court of the United States
OCTOBER TERM, 1980

---

MARK MILLS, *et al.*,
*Petitioners*

v.

RUBIE ROGERS, *et al.*,
*Respondents*

---

**On Writ of Certiorari to the United States Court of Appeals for the First Circuit**

---

## BRIEF FOR THE AMERICAN PSYCHIATRIC ASSOCIATION AS AMICUS CURIAE

---

JOEL I. KLEIN *
H. BARTOW FARR, III
ONEK, KLEIN & FARR
2550 M Street, N.W.
Washington, D.C. 20037
202-775-0184
* Counsel of Record

WILSON - EPES PRINTING CO., INC. - 789-0096 - WASHINGTON, D.C. 20001

## QUESTION PRESENTED

Whether a state, having validly committed a mentally ill patient, is then constitutionally disabled from treating his illness with medication unless he consents.

TABLE OF CONTENTS


| | Page |
|---|---|
| Interest of Amicus Curiae | 1 |
| Statement of the Case | 2 |
| Summary of Argument | 5 |
| Argument | 7 |
| I. A STATE MAY REQUIRE MENTALLY ILL PERSONS TO TAKE APPROPRIATE MEDICATION FOR TREATMENT PURPOSES AFTER THEY HAVE BEEN PROPERLY COMMITTED | 7 |
| A. The Decision To Commit Involves More Than Mere Isolation From Society | 7 |
| B. The Provision Of Effective Treatment, Where Possible, Is Essential To Carry Out The State's Interest In Civil Commitment | 14 |
| II. THE APPROACH MANDATED BY THE COURT OF APPEALS IS NEITHER CONSTITUTIONALLY REQUIRED NOR BENEFICIAL AS A MEANS OF IMPROVING TREATMENT OR PROTECTING PATIENTS | 21 |
| Conclusion | 28 |

## TABLE OF AUTHORITIES


| *Cases* | Page |
|---|---|
| *Addington* v. *Texas*, 441 U.S. 418 (1979) | *passim* |
| *A.E. Mitchell*, No. C78-466 (D. Utah, June 16, 1980) | 22 |
| *Bell* v. *Wolfish*, 441 U.S. 520 (1979) | 6, 14 |
| *Bowring* v. *Godwin*, 551 F.2d 44 (4th Cir. 1977) | 10 |
| *French* v. *Blackburn*, 428 F. Supp. 1351 (M.D.N.C. 1977), *aff'd summarily*, 443 U.S. 90 (1979) | 9, 10 |
| *Humphrey* v. *Cady*, 405 U.S. 504 (1972) | 6, 12 |
| *In the Matter of Spring*, 399 N.E. 2d 492 (Mass. App. 1979), *rev'd on other grounds*, 405 N.E. 2d 115 (Mass. S.J.C. 1980) | 11 |
| *Knecht* v. *Gillman*, 488 F. 2d 1136 (8th Cir. 1973) | 20 |
| *Logan* v. *Arafeh*, 346 F. Supp. 1265, (D. Conn. 1972), *aff'd summarily sub nom. Briggs* v. *Arafeh*, 411 U.S. 911 (1973) | 10 |
| *Meachum* v. *Fano*, 427 U.S. 215 (1976) | 14 |
| *Montayne* v. *Haynes*, 427 U.S. 236 (1976) | 14 |
| *Nason* v. *Superintendent of the Bridgewater State Hospital*, 353 Mass. 604, 233 N.E. 2d 908 (1968) | 19 |
| *Nelson* v. *Heyne*, 355 F. Supp. 451 (N.D. Ind. 1972), *aff'd*, 491 F. 2d 352 (7th Cir.), *cert. denied*, 417 U.S. 976 (1974) | 20 |
| *O'Connor* v. *Donaldson*, 422 U.S. 563 (1975) | *passim* |
| *Parham* v. *J.R.*, 442 U.S. 584 (1979) | *passim* |
| *Pennhurst State School and Hospital* v. *Halderman*, 49 U.S.L.W. 4363 (Apr. 20, 1981) | 1 |
| *Price* v. *Sheppard*, 307 Minn. 250, 239 N.W. 2d 905 (1976) | 13 |
| *Rennie* v. *Klein*, 462 F. Supp. 1131 (D.N.J. 1978) | *passim* |
| *Rogers* v. *Okin*, 478 F. Supp. 1342 (D. Mass. 1979), *aff'd in part*, 634 F. 2d 650 (1st Cir. 1980), *cert. granted*, 49 U.S.L.W. 3779 | *passim* |
| *Romeo* v. *Youngberg*, 644 F. 2d 147 (3d Cir. 1980), cert. granted, 49 U.S.L.W. 3851 (May 18, 1981) | 24 |
| *State* v. *Carter*, 316 A. 2d 449 (N.J. 1974) | 9 |

TABLE OF AUTHORITIES—Continued

Page

*Superintendent of Worcester State Hospital* v. *Hagberg*, 374 Mass. 271, 372 N.E. 2d 242 (1978) ..... 10
*Vitek* v. *Jones*, 445 U.S. 480 (1980) ..... 6, 12, 13
*Whitree* v. *State*, 56 Misc. 2d 693, 290 N.Y.S. 2d 486 (1968) ..... 19
*Winters* v. *Miller*, 446 F. 2d 65 (2d Cir.), *cert. denied*, 404 U.S. 985 (1971) ..... 12
*Wolff* v. *McDonald*, 418 U.S. 539 (1974) ..... 14
*Wyatt* v. *Aderholt*, 502 F. 2d 1305 (5th Cir. 1974) .. 10

*Statutes and Regulations*

42 U.S.C. § 1983 ..... 2
Alaska Stat. § 47.30.070(i) ..... 8
Ariz. Rev. Stat. Ann. § 36-540 ..... 9, 10
Calif. Welf. & Inst. Code § 5008(n) ..... 8
Ga. Code Ann. § 88-507.1 ..... 8
Iowa Code Ann. 229.1 ..... 8
Mass. Dept. Mental Health Reg. 220.2 ..... 11
Mass. Dept. Mental Health Reg. 223.03 ..... 20
Mas. Gen. Laws Ch. 123 §§ 1,4,5-8, 12 ..... 10, 11
New Mex. Stat. Ann. 34-2A-10 ..... 9
N.Y. Mental Hyg. Law § 31.31 ..... 9
So. Car. Code § 44-17-580 ..... 8
Utah Code Ann. § 64-7-37(10) ..... 22

*Books & Articles*

APA Task Force Report: Tardive Dyskinesia (1980) ..... 15
Appelbaum, *A.E. & R.R.: Utah's Compromise on the Right to Refuse Treatment*, 32 Hosp. & Comm. Psychiat. ..... 22
Appelbaum & Gutheil, *Drug Refusal: A Study of Psychiatric Inpatients*, 137 Amer. J. Psychiat. 340 (1980) ..... 18, 19
Appelbaum & Gutheil, *"Rotting With Their Rights On": Constitutional Theory and Clinical Reality in Drug Refusals by Psychiatric Patients*, 7 Bull. Amer. Acad. Psychiat. & Law, 308 (1979) ..... 16, 18, 19

TABLE OF AUTHORITIES—Continued

Page

R. Baldessarini, Chemotherapy in Psychiatry, (1977) ..... 14, 15, 16

Dershowitz, *The Origins of Preventive Confinement in Anglo-American Law—Part II: The American Experience*, 43 U. Cinn. L. Rev. 781 (1974) ..... 9

Dubose, *Of the Parens Patriae Commitment Power and Drug Treatment of Schizophrenia: Do the Benefits to the Patients Justify Involuntary Treatment*, 50 Minn. Law Rev. 1149 (1976) ..... 15

Goldman, *et al., Defining and Counting the Chronically Mentally Ill*, 32 Hosp. & Comm. Psychiat. 279 (1977) ..... 9

Gove & Fain, *A Comparison of Voluntary and Committed Psychiatric Patients*, 34 Arch. Gen. Psychiat. 669 (1977) ..... 17

Grossman & Summers, *A Study of the Capacity of Schizophrenic Patients to Give Informed Consent*, 31 Hosp. & Comm. Psychiat. 205 (1978) .. 26

Group for the Advancement of Psychiatry, Pharmacotherapy and Psychotherapy: Paradoxes, Problems and Progress (1975) ..... 16

Gutheil, *et al., Legal Guardianship in Drug Refusal: An Illusory Solution*, 137 Amer. J. Psychiat. 347 (1980) ..... 25

Hoffman, *The Right to Refuse Psychiatric Treatment: A Clinical Perspective*, 4 Bull. Amer. Acad. Psychiat. & Law 269 (1976) ..... 18

Janicak & Bonavich, *The Borderland of Autonomy: Medical-Legal Criteria for Capacity to Consent*, J. of Psychiat. and Law 361 (Winter 1980) ..... 22

D. Klein, Diagnosis and Drug Treatment of Psychiatric Disorders: Adults and Children, 28 *et seq.* (2d ed. 1980) ..... 18

Klerman, *National Trends in Hospitalization*, 30 Hosp. & Comm. Psychiat. 110 (1979) ..... 15

J. Lion, The Art of Medicating Psychiatric Patients 28 (1978) ..... 18

TABLE OF AUTHORITIES—Continued

Page

P. May, Treatment of Schizophrenia: The Comparative Study of Five Treatment Methods (1968) ..... 16

Meadow, *et al., Effects of Phenothiazines on Anxiety and Cognition in Schizophrenia,* 36 Diseases of the Nervous System 203 (1975) ..... 16

Michels, *The Right to Refuse Treatment: Ethical Issues,* 32 Hosp. & Comm. Psychiat. 251 (1981).. 23

Morris, *Conservatorship for the "Gravely Disabled": California's Nondeclaration for Nonindependence,* 1 Inter. J. Law & Psychiat. 395 (1978) ..... 26

*Note, The Use of Psychotropic Drugs in State Hospitals: A Legal or Medical Decision,* 29 Hosp. & Comm. Psychiat. 118 (1978) ..... 16

Ozarin, *et al., A Quarter Century of Psychiatric Care 1950-1984: A Statistical Review,* 27 Hosp. & Comm. Psychiat. 515 (1976) ..... 15

Peele, *et al., Involuntary Hospitalization on Treatability: Observations from the District of Columbia Experience,* 23 Cath. U. L. Rev. 744 (1974) ..... 17

Perr, *Effects of the Rennie Decision on Private Hospitalization in New Jersey,* 138 Amer. J. Psychiat. 774 (1981) ..... 25

Plotkin, *Limiting the Therapeutic Orgy: Mental Patients' Right to Refuse Treatment,* 72 Northwestern U. L. Rev. 461 (1977) ..... 15

Rachlin, Civil Commitment, Parens Patriae, and the Right to Refuse Treatment, 1 Amer. J. Forensic Psychiat. 174 (1979) ..... 13

Roth, *Clinical and Legal Considerations in the Therapy of Violence-prone Patients,* 18 Current Psychiatric Therapies 55 (Masserman Ed. 1978) ..... 18

Roth, *Involuntary Civil Commitment: The Right to Treatment and The Right to Refuse Treatment,* Psychiatrists and the Legal Process: Diagnosis & Debate 332 (1977) ..... 23

TABLE OF AUTHORITIES—Continued

Page

Roth, *et al.*, *Tests of Competency to Consent to Treatment*, 134 Amer. J. Psychiat. 279 (1977).... 22

Sata & Goldenberg, *A Study of Involuntary Patients in Seattle*, 28 Hosp. & Comm. Psychiat. 834 (1977) ..... 17

Spensley, *et al.*, *Involuntary Hospitalization: What For and How Long?* 131 Amer. J. Psychiat. 219 (1974) ..... 17

Spohn, *et al.*, *Phenothiazine Effects on Psychological and Psychophysiological Dysfunction in Chronic Schizophrenics*, 34 Arch. Gen. Psychiat. 633 (1977) ..... 16

State Laws Governing Civil Commitment, 3 Mental Disability Law Rptr. 206 (1979) ..... 8

Stone, *Informed Consent: Special Problems for Psychiatry*, 30 Hosp. & Comm. Psychiat. 251 (1979) ..... 22

Stone, *Mental Health Litigation: A Critical Perspective*, 134 Amer. J. Psychiat. 273 (1977)..... 25

Stone, *The Right to Refuse Treatment*, 38 Arch. Gen. Psychiat. 358 (1981) .....20, 22, 27

Weinstein, *Patient Attitudes Towards Mental Hospitalization: A Review of Quantitative Research*, 20 J. Health and Soc. Behavior 237 (1979) ..... 17

Witkin, Mental Health Statistical Note #153: Provisional Patient Movement and Selective Administrative Data, State and County Mental Inpatient Services by State (D. HEW Aug. 1979)..... 15

IN THE

# Supreme Court of the United States

OCTOBER TERM, 1980

No. 80-1417

MARK MILLS, *et al.*,

*Petitioners*

v.

RUBIE ROGERS, *et al.*,

*Respondents*

**On Writ of Certiorari to the United States Court of Appeals for the First Circuit**

## BRIEF FOR THE AMERICAN PSYCHIATRIC ASSOCIATION AS AMICUS CURIAE

### INTEREST OF AMICUS CURIAE

The American Psychiatric Association ("APA"), founded in 1844, is the nation's largest organization of physicians who specialize in psychiatry. Approximately 26,000 of the nation's 33,000 psychiatrists are members. Psychiatrists have the principal responsibility for providing expert testimony in civil commitment proceedings, and for providing treatment to committed patients as well as to others who suffer from mental illness. The APA has participated as amicus curiae in numerous cases involving mental health issues, including *O'Connor* v. *Donaldson*, 422 U.S. 563 (1975), *Addington* v. *Texas*, 441 U.S. 418 (1979), *Parham* v. *J.R.*, 442 U.S. 584 (1979), and *Pennhurst State School and Hospital* v. *Halderman*, 49 U.S.L.W. 4363 (Apr. 20, 1981).

The instant case has important implications for the treatment of civilly committed patients and, consequently, greatly affects the concerns and the work of the Associa-

tion and its members. The APA believes that its clinical experience and scientific knowledge can assist the Court in resolving the issues presented. This brief, filed in support of petitioners' claim that the decision below should be reversed, will seek to show that providing civilly committed patients with a right to refuse medication is constitutionally unwarranted and clinically unwise.

The parties have consented to the filing of this brief. Copies of their letters have been lodged with the Clerk.

## STATEMENT OF THE CASE

This class action was brought by several voluntary and involuntary psychiatric patients at Boston State Hospital, alleging constitutional deprivations in violation of 42 U.S.C. § 1983. Specifically, plaintiffs challenged the use of seclusion and compulsory psychiatric medication in nonemergency situations. After a lengthy trial, the district court (Tauro, J.) held, *inter alia*, that a committed patient has a right to refuse medication except "in an emergency situation in which a failure to [medicate] would result in a substantial likelihood of physical harm to that patient, other patients, or to staff members of the institution." *Rogers* v. *Okin*, 478 F. Supp. 1342, 1365 (D. Mass. 1979).[1]

---

[1] The court issued a similar ruling with respect to the use of seclusion. 478 F. Supp. at 1371-75. It further held that voluntary patients have a constitutional right to refuse medication and, moreover, that such patients must be allowed to remain at the hospital even if they persist in their refusals. *Id.* at 1367-68. Finally, the court rejected plaintiffs' claims for damages, finding that defendants' behavior fell within the good faith exception to § 1983, and that plaintiffs' state law tort claims had not been proved. *Id.* at 1375-89.

None of these issues are before this Court. Defendants did not appeal the district court's ruling on seclusion. The Court of Appeals affirmed the district court's decision rejecting damages, and reversed its holding on voluntary patients, finding instead that, while such patients may refuse medication, they cannot then de-

In reaching its decision, the court recognized that "[t]he prime purpose of any hospital is to treat . . . In the case of an involuntarily committed patient, Boston State has a duty to provide treatment." 478 F. Supp. at 1365. It also found that the psychiatrists "desired only to help plaintiffs," *id.* at 1382, and that the specific uses of compulsory medication at issue in this case constituted "reasonable medical practice." *Id.* at 1386. In fact, as a result of the medication, "most [plaintiffs] showed eventual improvement" without suffering serious side effects. *Ibid.* The court further stressed "plaintiffs' helplessness and dependency," and noted that the patient population generally "was extremely demanding, both in terms of numbers and their potential for disruptive behavior." *Id.* at 1382-83.

These factors notwithstanding, the court held that civilly committed patients have a constitutionally protected privacy right to refuse psychiatric medication. The rationale for the decision was that "[t]he committed patient . . . is in need of treatment, yet is presumed to be competent." *Id.* at 1366.[2] As a result, the court ruled, an objecting patient cannot be medicated in a nonemergency situation unless he has been declared incompetent at a judicial hearing, and a court-appointed guardian consents on his behalf.

On appeal, the Court of Appeals for the First Circuit (per Coffin, C.J.) issued a decision affirming in part, reversing in part, and remanding for further proceed-

---

mand to stay at the hospital. *Rogers* v. *Okin*, 634 F.2d 650, 661-63 (1st Cir. 1980). Plaintiffs have not sought review of these latter two issues.

[2] The court elaborated its constitutional analysis by stating that the "concept of a right of privacy also embodies First Amendment concerns." 478 F. Supp. at 1366. (footnote omitted). It then found that psychiatric medication was "mind-altering" and "mind control[ling,]" and therefore, that it impinged on the committed patient's "right to produce a thought—or refuse to do so . . ." *Id.* at 1367.

ings. *Rogers* v. *Okin*, 634 F. 2d 650 (1st Cir. 1980). The court started from the premise that individuals generally have a constitutional right to refuse serious medical treatments. It then considered the various justifications proposed for overriding that right when patients are civilly committed to state mental hospitals. Turning first to the state's police power—*i.e.*, its authority to commit the mentally ill to protect others from harm—the court held that this justification would sustain compulsory medication only in an "emergency." The court disagreed with the district court's definition of an emergency, however, finding instead that the proper test is whether "the need to prevent violence in a particular situation outweighs the possibility of harm [from medication] to the medicated individual." 634 F. 2d at 656.[3] The procedures necessary for making such an assessment were left for consideration by the district court on remand.

Next, the Court of Appeals turned to the *parens patriae* justification—*i.e.*, to protect or help the individual himself—for forcible medication. The court recognized that committed patients are often "in desperate need of care and treatment," 634 F. 2d at 655, and that "the possibility of [their] improvement as a result of forced treatment [with medication] is relatively substantial." *Id.* at 657. Nevertheless the court ruled that, before the *parens patriae* authority could be relied upon to justify compulsory medication, there must first be a judicial determination that the committed individual "lacks the capacity to decide for himself whether he should take

[3] The factors to be considered in making this determination include "an *individualized* estimation of the possibility and type of violence, the likely effects of particular drugs on a particular individual, and an appraisal of alternative, less restrictive courses of action." 634 F.2d at at 655-56 (emphasis in original). While suggesting that "it may be possible that in most [emergency] situations less restrictive means [than medication] will be available," *id.* at 656, the court did not identify such means. Instead, it instructed the district court to explore the matter on remand.

the drugs." 634 F. 2d at 657.[4] Scrutinizing Massachusetts commitment law, the court found that it did not, in fact, provide for such a judicial determination.[5]

This Court granted certiorari on April 20, 1981. 49 U.S.L.W. 3779.

## SUMMARY OF ARGUMENT

This case raises the important question whether a state, having validly committed a mentally ill patient, is then constitutionally disabled from treating his illness with medication unless he consents. The Court of Appeals paid little attention to this question, quickly finding a right to refuse medication and focusing instead on the situations in which the right can be overriden or deemed to have been incompetently asserted. This analysis unfortunately gives the wrong answer to the wrong question. The APA believes that, regardless of capacity, a state may require persons to take appropriate medication for treatment purposes provided that they have been properly committed.

1. Civil commitment requires a finding that an individual is both mentally ill and a danger to himself or others, or unable to care for himself. See *O'Connor* v. *Donaldson*, 422 U.S. 563 (1975). These criteria must be proved by clear and convincing evidence. See *Addington*

---

[4] The court further indicated that a judicial hearing could be dispensed with in "emergency circumstances . . . where any delay could result in significant deterioration of the patient's mental health." 634 F.2d at 660. The district court was instructed to devise "alternative means for making competency determinations in [such circumstances]." *Ibid.*

[5] In contrast to the district court, the First Circuit further held that it was not necessary to appoint a guardian as a substitute decisionmaker for incompetent patients. Instead, the state was authorized to devise more informal procedures—such as, for example, medical peer review—for making substitute decisions. Defining the substance of these less formal procedures was also left for the district court on remand.

v. *Texas*, 441 U.S. 418 (1979). Once they have been proved, however, they are sufficient to support not only the initial deprivation of liberty but also the imposition of ancillary conditions, like treatment, that are essential to effectuating the purposes of the deprivation. Cf. *Bell* v. *Wolfish*, 441 U.S. 520, 538-39 (1979). Since a mentally ill patient may be committed without his consent, it follows that his illness may be treated without his consent. See *Humphrey* v. *Cady*, 405 U.S. 504, 508 (1972); *Addington* v. *Texas*, *supra*, 441 U.S. at 426-27; *Vitek* v. *Jones*, 445 U.S. 480, 493 (1980).

The provision of treatment is plainly an essential part of civil commitment. Commitment has been shown to be an effective form of societal intervention, in large part due to the discovery and use of the medications at issue in this case. Although it is preferable to enlist the patient's cooperation in taking medication, and although there are times when it is clinically appropriate to honor patient refusals, the plain fact is that, for treatment to be most effective, the psychiatrist must retain the authority to administer medication over objection when necessary.

2. To focus on the capacity to consent as a means of overriding medication refusals creates more problems than it solves. Capacity is always a complicated subject when dealing with seriously mentally ill patients. The matter is made worse by the fact that hospitalization involves numerous treatment decisions over a time period in which the patient's capacity and understanding will change significantly, in part depending on whether he is taking medication. Nor is there any reason to restrict capacity inquiries to *objecting* patients. If capacity is the constitutional test, the *consenting* patient's capacity should also be subject to judicial review.

These factors inevitably will mean that the rule adopted below will be costly, both in terms of added procedures and in terms of delayed treatment. See *Parham* v. *J.R.*, 442 U.S. 584, 604-06 (1979). Such costs are not

matched by corresponding benefits. Capacity hearings are likely to be ritualistic reenactments of commitment hearings, in which courts typically will defer to medical judgments regarding capacity and the need for medication. Moreover, even when a patient is found to possess the requisite capacity, and his treatment refusals are then honored, his autonomy may well be respected only at the expense of his liberty, as commitment is transformed into prolonged custodial detention.

## ARGUMENT

### I. A STATE MAY REQUIRE MENTALLY ILL PERSONS TO TAKE APPROPRIATE MEDICATION FOR TREATMENT PURPOSES AFTER THEY HAVE BEEN PROPERLY COMMITTED.

Although the Court of Appeals held that "medication cannot be forcibly administered solely for treatment purposes absent a finding of incompetency," 634 F.2d at 656, the APA believes that this view is unsupported either by constitutional doctrine or clinical judgment. It is the position of the APA that, once a person has been involuntarily committed, he may be given medication without his consent, provided that it is administered for treatment purposes and is consistent with acceptable medical practice.

#### A. The Decision To Commit Involves More Than Mere Isolation From Society.

To address this issue properly, we think it necessary to understand both the process of involuntary commitment and the role of treatment following commitment. By definition, of course, involuntary commitment involves the separation of a person from society without his consent. To assure that such commitment is justified, this Court has placed limits on the substantive criteria that can be used, see *O'Connor* v. *Donaldson*, *supra*, and has required that proof of those substantive criteria be established by clear and convincing evidence. See *Adding-*

*ton* v. *Texas, supra.* Upon meeting that burden, however, a state may confine someone over his objection and without any need to show that he is incompetent to choose or reject commitment on his own.

The substantive criteria for civil commitment in every state include, as the essential requirement, that the person be mentally ill. See State Laws Governing Civil Commitment, 3 Mental Disability Law Rptr. 206 (1979). It is evident, moreover, that the required finding of mental illness is not to be made lightly. "Loss of liberty calls for a showing that the individual suffers from something more serious than is demonstrated by idiosyncratic behavior." *Addington* v. *Texas, supra,* 441 U.S. at 427. While necessary, however, the fact of mental illness is not sufficient to support involuntary commitment. See *O'Connor* v. *Donaldson, supra.* To protect against sequestration of a person merely because he is ill, the states uniformly require a showing that the person is also dangerous to himself or others, or is unable to care for himself.[6]

By insisting on these latter criteria, it is apparent that commitment has, as *one* of its purposes, the protection of the individual or others. But it is equally plain that protection is not the *sole* function of commitment. Other-

---

[6] A detailed state-by-state listing of commitment criteria is set forth at 3 Mental Disability Law Rptr. 206-214 (1979). Most states essentially use mental illness and danger to self or others as the governing criteria. Several states also use an "in need of care" standard in addition to the dangerousness standard. Those states typically define "in need of care" in terms of the individual's inability to provide for his basic needs, such as food or shelter, or to protect his own physical wellbeing. See, e.g., Calif. Welf. & Inst. Code § 5008(n); Ga. Code Ann. § 88-507.1. A very few states include inability to seek treatment as part of the "in need of care" standard, but those states specifically require that, in such instances, the person also found to lack the "capacity to make responsible decision concerning hospitalization." Alaska Stat. § 47.30.070(i). See also Iowa Code Ann. 229.1; So. Car. Code § 44-17-580.

wise, there would be no reason to restrict its application to the mentally ill. Rather, by requiring a finding of mental illness as an indispensable element, the states make clear that commitment seeks to serve a curative function as well.[7]

As an historical matter, it has been shown that commitment laws in this country developed not out of a desire to isolate the mentally ill, but instead as a means by which to provide them with beneficial care. See, e.g., Dershowitz, *The Origins of Preventive Confinement in Anglo-American Law—Part II: The American Experience*, 43 U. Cinn L. Rev. 781, 807-809 (1974). This historical concern has not remained static. As the court below recognized, "due in large part to the development of numerous drugs for treating mental illness . . . the state today finds its interest in being able to offer meaningful assistance to the individual even more substantial than it was in previous times." 634 F.2d at 650. As a result, many state legislatures have specifically said that treatment necessarily follows from the act of involuntary commitment. See, e.g., Ariz. Rev. Stat. Ann. § 36-540; New Mex. Stat. Ann. § 34-2A-10; N.Y. Mental Hyg. Law § 31.31. In other states, the importance of treatment has been established by judicial decisions. See, e.g., *French* v. *Blackburn*, 428 F. Supp. 1351, 1354 (M.D.N.C. 1977), *aff'd summarily*, 443 U.S. 901 (1979); *State* v. *Carter*, 316 A. 2d 449, 456 (N.J.

---

[7] We recognize that there are some forms of mental illness that are not readily or effectively treated, and that for persons suffering from such illness commitment serves more of a maintenance than a curative function. See *O'Connor* v. *Donaldson*, *supra*, 422 U.S. at 580-85 (Burger, C.J., concurring). Increasingly, the number of such people is declining, both because medical knowledge is advancing and because people needing custodial care are being placed in facilities other than state hospitals. See Goldman, *et al.*, *Defining and Counting the Chronically Mentally Ill*, 32 Hosp. & Comm. Psychiat. 21 (1981). In any event, our argument in this case applies only to patients for whom medication is deemed to be appropriate treatment.

1974) (treatment is "inherent in the rationale [for commitment]"). To our knowledge, there is no state that claims the authority to confine the mentally ill without any effort to alleviate, or at least to prevent the deterioration of, the illness that permitted confinement in the first place. See, e.g., *Bowring* v. *Godwin*, 551 F. 2d 44, 48 (4th Cir. 1977); *Wyatt* v. *Aderholt*, 503 F. 2d 1305, 1312-14 (5th Cir. 1974).

The commitment process at issue in this case is fully consistent with these principles. Civil commitment of the mentally ill in Massachusetts may be accomplished only after an individual has been accorded full due process protections, including a judicial hearing at which the individual is represented by counsel. M.G.L. Ch. 123, §§ 5-8.[8] At the hearing the state must prove beyond a reasonable doubt (rather than just by clear and convincing evidence) both that the individual is mentally ill and that the failure to commit him would create a likelihood of serious harm. See *id.* at § 8; *Superintendent of Worcester State Hospital* v. *Hagberg*, 374 Mass. 271, 372 N.E. 2d 242 (1978). For purposes of commitment, a "likelihood of serious harm" requires a showing that the

[8] For a period of up to 10 days, an individual can be hospitalized on an emergency basis upon the petition of a licensed physician who has determined, after examination, that "failure to hospitalize such person would create a likelihood of serious harm by reason of mental illness." M.G.L. Ch. 123, § 12. If a physician is not available, a police officer may make the application for admission but the individual must then be examined by a designated physician immediately upon his arrival at the hospital. *Ibid.* In all instances, the patient must be released within 10 days unless the superintendent applies for commitment, entitling the patient to a judicial hearing. *Id.* at §§ 7, 8, 12. In addition, any other individual can apply for an emergency 10-day commitment of a mentally ill person, but such commitments require a judicial hearing. *Id.* at § 12. These procedures plainly satisfy due process demands. See *French* v. *Blackburn*, 428 F. Supp. 1351 (M.D.N.C. 1977), *aff'd summarily*, 443 U.S. 901 (1979); *Logan* v. *Arafeh*, 346 F. Supp. 1265 (D. Conn. 1972), *aff'd summarily sub nom. Briggs* v. *Arafeh*, 411 U.S. 911 (1973).

individual is either self-assaultive, or violent toward others, or so incapable of caring for himself that physical harm is likely to result. M.G.L. Ch. 123, § 1. As the Court of Appeals acknowledged, this "commitment scheme . . . goes well beyond the minimum requirements mandated by the Fourteenth Amendment." 634 F.2d at 650 (footnote omitted).

It is also clear that in Massachusetts the need for treatment is an essential corollary of the commitment process. Whether the state is relying on its police power or its *parens patriae* power, the committed patient must be in need of "care and treatment," M.G.L. Ch. 123, § 4, and such treatment must in fact be provided. See *In the Matter of Spring*, 399 N.E.2d 493, 510 n.10 (Mass. App. 1979), *rev'd on other grounds*, 405 N.E.2d 115 (Mass. S.J.C. 1980) ("the state has a legal obligation to provide needed care to a person involuntarily committed to a state institution."). Consistent with this recognition, the State Department of Mental Health has provided that all patients "shall receive treatment and rehabilitation in accordance with accepted therapeutic practice, including oral, subcutaneous and intramuscular medication when appropriate and when ordered by a physician." D.M.H. Reg. 220.02. Like other states, therefore, Massachusetts assures that the provision of needed treatment is one of the conditions that attaches to all commitments, provided, of course, that the requisite findings of mental illness and dangerousness (or inability to care for oneself) have been made.[9]

---

[9] The Court of Appeals attempted to distinguish between the police power justification for compulsory medication, on the one hand, and the *parens patriae* justification on the other. See pp. 4-5, *supra*. To the extent that the court meant to suggest that, in particular circumstances, medication should be used as a means of preventing violence, its analysis is misguided. See note 18, *infra*. Alternatively, if the court thought that Massachusetts only intends to provide treatment to patients committed pursuant to its *parens patriae* power, and not its police power, the court simply misunderstood state law, as the discussion in text indicates.

It is thus plain, and indeed undisputed in this case, that proper findings, including a finding of mental illness, justify the *commitment* of persons without their consent. The question here is simply whether the same findings justify *treatment* without their consent as well. The Court of Appeals, without much discussion, concluded that they did not. In our own view, that decision is incorrect.[10]

To begin with, this Court appears to have recognized, if not decided, that commitment involves more than just the deprivation of liberty to remain at large. In *Vitek* v. *Jones*, *supra*, for example, in concluding that imposition of a prison sentence does not itself justify involuntary commitment to a mental hospital, the Court drew a specific distinction between the power to subject an individual to a prison sentence and the power, exercised through involuntary commitment, "to classify him as mentally ill and to subject him to involuntary psychiatric treatment." 445 U.S. at 493. This understanding is consistent with the language of earlier opinions where the Court acknowledged that commitment traditionally involves "compelled treatment" (*Addington* v. *Texas*, *supra*, 441 U.S. at 427) or "compulsory psychiatric treatment" (*Humphrey* v. *Cady*, *supra*, 405 U.S. at 508). In none of these cases did the criteria for commitment include lack of capacity; nor did the Court suggest the need for such a criterion. Without regarding such references as dispositive, we think they do imply

---

[10] The sole case cited by the Court of Appeals to support its conclusion, see *Winters* v. *Miller*, 446 F.2d 65, 71 (2d Cir.), *cert. denied*, 404 U.S. 985 (1971), is not on point. That case involved a civilly committed Christian Scientist, who had objected to all forms of medication long before commitment. In view of the special First Amendment concerns presented by the religious objection, a divided panel of the Second Circuit held that a competency hearing was required before medication could be administered. The instant case, by contrast, does not involve medication refusals based on religious grounds.

a view that involuntary commitment is broad enough to embrace involuntary treatment as well.

This Court has also recognized that "the state has a proper interest in providing care and assistance to the unfortunate." *O'Connor* v. *Donaldson*, *supra*, 422 U.S. at 575. See also *Addington* v. *Texas*, *supra*, 441 U.S. at 426 ("state has a legitimate interest under its *parens patriae* powers in providing care to its citizens who are unable because of emotional disorders to care for themselves"). There is no reason to assume that this interest ends at the hospital door. To the contrary, a state has a heightened interest in providing the sort of care and treatment that will restore committed patients to their place in society. It does little to advance this interest to hold that the state, having assumed custody, must then stand helplessly by while individuals refuse the treatment that they were committed to receive.[11]

We think it more reasonable to conclude that treatment, including compulsory medication if medically indicated, is "within the range of conditions of confinement to which [civil commitment] subjects an individual." *Vitek* v. *Jones*, *supra*, 445 U.S. at 493. In other contexts, this Court has noted that, once an original depri-

---

[11] See *Price* v. *Sheppard*, 307 Minn. 250, 239 N.W. 2d. 905, 911 (1976):

> "The question in the case before us is whether the state, consistent with [plaintiff's] right of privacy, can assume the decision of whether [plaintiff], an involuntarily committed patient, will undergo psychiatric treatment. We observe that the more fundamental decision, whether he was to undergo hospitalization, was assumed by the state at the commitment proceeding, the validity of which is not contested.
>
> . . . If th[e] interest of the state is sufficiently important to deprive an individual of his physical liberty, it would seem to follow that it would be sufficiently important for the state to assume the treatment decision. We hold that it is."

See also, Rachlin, *Civil Commitment, Parens Patriae, and the Right to Refuse Treatment*, 1 Amer. J. Forensic Psychiat. 174 (1979).

vation of liberty is proper, the state is then empowered "to employ devices that are calculated to effectuate [the purpose of] this detention." *Bell* v. *Wolfish*, *supra*, 441 U.S. at 537. Such ancillary conditions are permissible even if they result in a loss of individual "privacy." *Ibid.* See also *Meachum* v. *Fano*, 427 U.S. 215, 224 (1976); *Montayne* v. *Haynes*, 427 U.S. 236 (1976); *Wolff* v. *McDonald*, 418 U.S. 539 (1974). As we discuss in the next section, it is clear that the provision of treatment, including appropriate medication, is well calculated to serve the legitimate purposes of commitment.

**B. The Provision Of Effective Treatment, Where Possible, Is Essential To Carry Out The State's Interest In Civil Commitment.**

A rational program of civil commitment necessarily involves resort to appropriate medication. Indeed, to the extent that civil commitment has been a successful endeavor, it is largely due to the advent of the major psychiatric medications in the 1950's.[12] These medications, particularly the antipsychotics, have had the kind of dramatic effect on the treatment of mental illness that antibiotics have had in the treatment of general illness. See R. Baldessarini, Chemotherapy in Psychiatry 36 (1977). Psychiatric hospital populations have declined substantially, from 512,501 in 1950 to 170,619 in 1976, and the decline has continued. See Ozarin,

[12] There are three major categories of medication commonly used in the treatment of committed patients: the antipsychotics, lithium, and the antidepressants. The antipsychotics are used in treating psychoses, particularly schizophrenia. They work by reducing disorders of thought, such as hallucinations and delusions. See generally R. Baldessarini, Chemotherapy in Psychiatry, Ch. 2 (1977). Lithium operates primarily on mood, rather than thought, disorders. It is generally used to reduce the grandiosity, elation and aggressiveness that characterize the manic phase of manic-depressive psychosis. See *id.* at Ch. 3. The antidepressants are also used to remedy mood disorders, particularly the sense of helplessness and despondency that characterizes a psychotic depression. See *id.* at Ch. 4.

*et al., A Quarter Century of Psychiatric Care 1950-1974: A Statistical Review*, 27 Hosp. & Comm. Psychiat. 515 (1956); Witkin, Mental Health Statistical Note #153: Provisional Patient Movement and Selective Administrative Data, State and County Mental Hospitals Inpatient Services by State (D. HEW Aug. 1979). The use of medications has also enabled patients to be hospitalized for far shorter periods of time—from a median hospital stay of 44 days in 1971 to 26 days in 1975—and has shifted the primary locus of care from the hospital to community treatment programs. See Klerman, *National Trends in Hospitalization*, 30 Hosp. & Comm. Psychiat. 110, 111-112 (1979). See also *Rennie* v. *Klein*, 462 F. Supp. 1131, 1137 (D.N.J. 1978). For patients helped by medication, therefore, the loss of liberty inherent in confinement may be significantly reduced.[13]

---

[13] Despite their acknowledged efficacy, antipsychotic medications have recently come under attack by lawyers claiming that their negative side-effects outweigh their benefits. See, e.g., Dubose, *Of the Parens Patriae Commitment Power and Drug Treatment of Schizophrenia: Do the Benefits To The Patients Justify Involuntary Treatment*, 50 Minn. Law Rev. 1149 (1976); Plotkin, *Limiting the Therapeutic Orgy: Mental Patients' Right to Refuse Treatment*, 72 Northwestern U. L. Rev. 461 (1977). The facts, however, will not support the rhetoric.

Most of the side effects of antipsychotic medications are temporary and readily reversible. See R. Baldessarini, Chemotherapy in Psychiatry, *supra* at 43-44. The most serious side effect is tardive dyskinesia, which involves involuntary or semi-involuntary tic-like movements, generally of the tongue, facial and neck muscles. *Id.* at 46. While none of the plaintiffs in this case suffered from tardive dyskinesia, see 478 F. Supp. at 1360, the problem is a serious one, and has merited significant clinical concern and scientific attention. See APA Task Force Report: Tardive Dyskinesia (1980). The report indicates that tardive dyskinesia occurs almost always after very prolonged use of antipsychotic medication, and that there are many new developments respecting its effective treatment and management. In any event, it is clear from a medical point of view that "the overwhelming preponderance of data supports a high benefit/risk ratio for [antipsychotic] medications and a safety record commensurate with other powerful pharmacologic agents." See Appel-

It is also true that the large majority of patients sufficiently ill to require commitment are benefitted by medication. See P. May, Treatment of Schizophrenia: A Comparative Study of Five Treatment Methods (1968); Group for the Advancement of Psychiatry, Pharmacotherapy and Psychotherapy: Paradoxes, Problems and Progress (1975). Although the district court characterized the medications at issue as "mind-controlling," they in fact act as an "enabler," reducing the level of grossly distorted thinking.[14] The decrease in distorted thinking in turn increases the patient's chance to derive long-term benefits from the psychotherapy and milieu therapy being provided. See *Rennie* v. *Klein*, *supra*, 462 F. Supp. at 1137; Note, *The Use of Psychotropic Drugs in State Hospitals: A Legal or Medical Decision*, 29 Hosp. & Comm. Psychiat. 118, 121 (1978).

The programs developed by states to treat involuntarily committed patients, while inevitably limited by the availability of resources, are thus more than just a wasted effort: they have positive and significant effects.

---

baum & Gutheil, *"Rotting With Their Rights On": Constitutional Theory and Clinical Reality in Drug Refusals by Psychiatric Patients*, 7 Bull. Amer. Acad. Psychiat. & Law 308, 309 (1979).

[14] See Appelbaum & Gutheil, *"Rotting With Their Rights On"*, *supra*, 7 Bull. Amer. Acad. Psychiat. & Law at 310 (footnote omitted):

> In fact, properly used, psychotropic medications are chemically normative in their mechanism of action: that is, they restore existing imbalance toward the balanced norm. They are generally incapable of creating thoughts, views, ideas or opinions *de novo*, or of permanently inhibiting the process of thought generation. Thus, the psychotic conformist, cured of his psychosis with medications, remains the conformist; the depressed rebel, cured of his depression, remains the rebel still.

See also Spohn, *et al.*, *Phenothiazine Effects on Psychological and Psychophysiological Dysfunction in Chronic Schizophrenics*, 34 Arch. Gen. Psychiat. 633 (1977); Meadow, *et al.*, *Effects of Phenothiazines on Anxiety and Cognition in Schizophrenia*, 36 Diseases of the Nervous System 203, 207 (1975).

Although it is always preferable from a medical viewpoint to treat patients who voluntarily seek help, the reported studies indicate that even involuntary patients generally experience "a very discernible improvement" as a result of hospitalization. Gove & Fain, *A Comparison of Voluntary and Committed Psychiatric Patients*, 34 Arch. Gen. Psychiat. 669, 671 (1977).[18] Most available accounts, in fact, indicate that involuntary patients themselves later view their hospitalization as beneficial. See *id.* at 675; Weinstein, *Patient Attitudes Towards Mental Hospitalization: A Review of Quantitative Research*, 20 J. Health and Soc. Behavior 237 (1979).

To commit and not treat, therefore, is to disregard not only a critical reason for commitment, but also an effective means for achieving that purpose. In fact, the provision of treatment (including appropriate medication) is not simply one of several acceptable ways for helping the involuntarily committed patient; when medically appropriate, it is the only way to assure that the commitment serves the purpose for which it is tolerated in our society. Unless the commitment process is to be regarded as an authorization for seclusion alone, a mentally ill person having been properly committed should have no greater right to refuse treatment for his illness than he has to resist the commitment itself.

We emphasize that the right to give medication without consent does not always mean, of course, the duty to do so. As is true with virtually any form of treatment, the most effective utilization of these medications occurs when the psychiatrist and patient work together in a

---

[18] See also Spensley, *et al.*, *Involuntary Hospitalization: What For and How Long?* 131 Amer. J. Psychiat. 219, 222 (1974); Sata & Goldenberg, *A Study of Involuntary Patients in Seattle*, 28 Hosp. & Comm. Psychiat. 834 (1977); Peele, *et al.*, *Involuntary Hospitalization and Treatability: Observations from the District of Columbia Experience*, 23 Cath. U. L. Rev. 744 (1974).

therapeutic alliance. See generally *O'Connor* v. *Donaldson, supra*, 422 U.S. at 584 (Burger, C.J., concurring). Thus, the APA fully supports the notion that the medication and its effects should be discussed with the patient, and his cooperation in taking the medication should be enlisted. See D. Klein, *et al.*, Diagnosis and Drug Treatment of Psychiatric Disorders: Adults and Children 28 *et seq.* (2d ed. 1980); Roth, *Clinical and Legal Considerations in the Therapy of Violence-prone Patients*, in 18 Current Psychiatric Therapies 55, 61 (Masserman ed. 1978). Similarly, there are occasions when it is clinically sensible to delay medication in the face of a patient objection. See Appelbaum & Gutheil, *Drug Refusal: A Study of Psychiatric Inpatients*, 137 Amer. J. Psychiat. 340, 345 (1980) ("Permitting both situational and sterotypic refusers in our study to decline medication, not as a 'right' but as a matter of clinical policy, did not seriously impair their overall treatment and yielded some positive advantages"); J. Lion, The Art of Medicating Psychiatric Patients 28 (1978).

While a decision to withhold medication thus may at times be the best approach to treatment, at other times effective clinical care demands that the physician be allowed to overrule the committed patient's objections. In some cases, for example, patients will simply remain defiant, or their verbal objections will be accompanied by behavior demonstrating ambivalence about treatment and the loss of their illnesses. See Hoffman, *The Right to Refuse Psychiatric Treatment: A Clinical Perspective*, 4 Bull. Amer. Acad. Psychiat. & Law 269, 271-73 (1976); Appelbaum & Gutheil, *"Rotting With Their Rights On"*, *supra*, 7 Bull. Amer. Acad. Psychiat. & Law at 315.[16]

---

[16] The authors report a study of 23 patients who accounted for 72 discrete episodes of drug refusal. The stated reasons—sometimes more than one reason was given—for these refusals were as follows: no reason offered (nine patients); angry or seemingly irrelevant responses (seven patients); side effects (10 patients);

Treatment can still be effective in such circumstances, see 634 F. 2d at 657, and the failure to impose it is considered irresponsible. Thus, the Massachusetts Supreme Judicial Court criticized a psychiatric hospital because "[d]rugs were not . . . administered involuntarily where patients refused medication." *Nason* v. *Superintendent of the Bridgewater State Hospital*, 353 Mass. 604, 233 N.E. 2d 908, 912 n.7 (1968).[17] In the final analysis, then, it is the physician, responsible for the patient's day-to-day care, who is best able to make the delicate clinical judgment of when to give medication despite the objections of a committed patient.

This does not mean that the process of commitment provides the states (or their physicians) a roving license to give medication. Because it is *treatment* of mental illness that is at the heart of the commitment process, we think that use of medication for purposes of restraint rather than treatment is outside the scope of conditions

---

overt delusions (nine patients); privacy (eight patients); legal rights (three patients). Appelbaum & Gutheil, *"Rotting With Their Rights On"*, *supra*, 7 Bull. Amer. Acad. Psychiat. & Law at 312-13. In another article, the authors divided these 23 patients into three groups: "(1) situational refusers [13 patients]—a diverse group of patients who on occasion refused medication for a short period of time and for one of a variety of reasons; (2) stereotypic refusers [five patients]—chronically ill patients with paranoid traits who habitually and predictably responded to a variety of stresses with brief medication refusal; and (3) symptomatic refusers [five patients]—young, relatively acutely ill patients whose refusal, often based on delusional premises, was sustained over a long period and successfully stymied treatment efforts." Appelbaum & Gutheil, *Drug Refusal: A Study of Psychiatric Inpatients*, *supra*, 137 Amer. J. Psychiat. at 342-44.

[17] See also *Whitree* v. *State*, 56 Misc. 2d 693, 290 N.Y.S. 2d 486, 501 (1968):

> We find [plaintiff] was not treated with any of the modern [psychiatric] drugs or any of their less effective antecedents during his entire stay in the hospital. It was not until 1959 . . . that such drugs were prescribed. We find that the reason for not using such drugs was that Whitree refused them. We consider such reason to be illogical, unprofessional and not consonant with prevailing medical standards.

reasonably incident to commitment.[18] Also outside that scope, though for different reasons, are unusual or experimental forms of treatment (such as psychosurgery or untested drugs), which cannot be said to be part of a recognized treatment program. See, e.g., *Knecht* v. *Gillman*, 488 F.2d 1136, 1138 (8th Cir. 1973) ("use of [pain-inducing] drug is not a recognized and acceptable medical practice"). And malpractice remains malpractice: the negligent or improper use of medication is not a legitimate part of commitment. The state has no cognizable interest in the abuse of medication. See, e.g., *Nelson* v. *Heyne*, 355 F. Supp. 451 (N.D. Ind. 1972), *aff'd*, 491 F.2d 352 (7th Cir.), *cert. denied*, 417 U.S. 976 (1974) (medication improperly used for control, not treatment, and administered without medical evaluation).

The guiding principle is thus a narrow one: just as a state may commit persons without consent, pursuant to proper findings, so it may treat them with appropriate medication without consent. Treatment, including the use of the proper medication, is an important, even necessary, part of commitment, serving the states' interest in caring for their own citizens. Indeed, commitment without treatment, or treatment without use of indicated medication, would often be worse than no commitment or treatment at all. The right to refuse treatment, like the right to refuse commitment itself, must therefore yield once the state has shown by clear and convincing evidence that a person requires commitment and treatment for his mental illness.

---

[18] Curiously, the Court of Appeals, by authorizing compulsory medication to control violence, but not for treatment, appears to have adopted precisely the opposite approach. See note 9, *supra*. As a clinical matter, the use of medication as a restraint undermines its treatment efficacy and is subject to great abuse. Such usage is thus uniformly condemned in the literature. See e.g., Stone, *The Right to Refuse Treatment*, 38 Arch. Gen. Psychiat. 358, 361 (1981). Other forms of intervention, such as physical restraint or seclusion, are indicated when a patient is uncontrollable. Consistent with this recognition, Massachusetts prohibits the use of medication as a form of restraint, instead limiting its use to being "part of a planned [treatment] program" D.M.H. Reg. 223.03.

## II. THE APPROACH MANDATED BY THE COURT OF APPEALS IS NEITHER CONSTITUTIONALLY REQUIRED NOR BENEFICIAL AS A MEANS OF IMPROVING TREATMENT OR PROTECTING PATIENTS.

The Court of Appeals, accepting with an uncritical eye a right to refuse medication after commitment, concentrated its attention on the rare emergency situations in which the right could be overridden and, especially, on the measures by which the competency to assert the right could be tested. This emphasis on the matter of competency, while superficially appealing, in fact further confuses an already confusing issue. At the same time, it needlessly cuts back the ability of the states to help their mentally-ill citizens.

It should be stressed at the outset that the issue of competency arises only as a consequence of recognizing the post-commitment right to refuse treatment. As we have discussed, pages 8-10, *supra*, the question of competency is not part of the commitment process itself, a process arguably involving a far greater deprivation of liberty and privacy than the giving of medication. To commit, the state need only show mental illness and dangerousness to self or others (or an inability to care for oneself), not that the person is incompetent to choose or reject commitment. Because consent to involuntary commitment is not required, the issue of capacity to consent simply does not arise.

The Court of Appeals nevertheless found it desirable to create a post-commitment right to refuse appropriate medication, while providing the state an opportunity to show that the refusal was prompted by incompetency or incapacity. Even leaving aside its doubtful constitutional heritage, this approach suffers from several practical flaws. First, it depends upon a factual determination (incapacity) that is hopelessly inconstant. Second, it requires inquiries that are limitless in scope and number. Third, and as a consequence of the first two, it will place a substantial drain on already limited state resources.

Fourth, it may greatly delay the administration of effective treatment. This Court should not strain to fashion a constitutional rule that so disserves the purposes of authorized commitment.[19]

In the first place, capacity is simply an ill-suited standard for coping with patient refusals during an on-going treatment program involving the administration of medication. Even as a legal standard, the concept of capacity often varies significantly in different jurisdictions and under varying circumstances. See, e.g., Roth, *et al.*, *Tests of Competency to Consent to Treatment*, 134 Amer. J. Psychiat. 279 (1977) (five different tests of capacity currently in use); Janicak & Bonavich, *The Borderland of Autonomy: Medical-Legal Criteria for Capacity to Consent*, J. of Psychiat. and Law 361 (Winter, 1980). The application of these standards to people who are seriously mentally ill is at best a flawed endeavor, even when dealing with one-time medical decisions. See, e.g., Stone, *Informed Consent: Special Problems for Psychiatry*, 30 Hosp. & Comm. Psychiat. 321 (1979). This problem is obviously exacerbated when a competency approach is applied to an extended period of hospitalization involving many medical decisions. A patient's judgment and capacity will change dramatically during such a period, often depending on whether he is being medicated. See *Rennie* v. *Klein*, *supra*, 462 F. Supp. at 1141 ("[plain-

[19] To our knowledge, only Utah requires an initial finding of "incapacity to consent to treatment" as a precondition of all commitments. See Utah Code Ann. § 64-7-36(10); *A.E.* v. *Mitchell*, No. C78-466 (D. Utah, June 16, 1980). While such an approach might unwisely restrict those who could properly benefit from civil commitment, see Appelbaum, *A.E. & R.R.: Utah's Compromise on the Right to Refuse Treatment*, 32 Hosp. & Comm. Psychiat. 167 (1981), it at least has the virtues of eliminating the need for separate hearings on commitment and capacity, and avoiding the costly result of hospitalizing patients without treating them. See Stone, *The Right To Refuse Treatment*, *supra*, 38 Arch. Gen. Psychiat. at 360-62.

tiff's] capacity to participate in the refusal of medicine or the choice of medicine is somewhat limited, depending on the day."); Roth, *Involuntary Civil Commitment: The Right to Treatment and The Right to Refuse Treatment*, in Psychiatrists and the Legal Process: Diagnosis & Debate 332, 243 (1977) ("patient competency is continually changing, even as a result of treatment"). An initial judicial determination of capacity is thus largely symbolic in a system involving on-going treatment decisions for mentally ill patients.

Moreover, if a post-commitment right to refuse medication is recognized, it would seem that the state must conduct innumerable inquiries into competency before any significant treatment is administered. Nowhere, for example, does the Court of Appeals explain why it limits the capacity requirement to patients who *object* to medication. If capacity is the controlling factor, then the *consenting* patient, especially when known to be mentally ill, presumably should also have a judicial hearing to assure that his consent is legally valid. See, e.g., Michels, *The Right to Refuse Treatment: Ethical Issues*, 32 Hosp. & Comm. Psychiat. 251, 252 (1981). It makes little sense to assume that patients who take medication are competent, while those who refuse are not.

Nor does the Court of Appeals satisfactorily explain why it expressly limited its ruling to antipsychotic medication, which is only one group of the psychiatric medications regularly used with committed patients. See 634 F.2d at 653 n. 1. See also note 12, *supra*. The articulated basis for this distinction is that the antipsychotics have "potentially harmful side effects . . ." 634 F.2d at 653 n. 1. But if capacity is the constitutional measuring rod, assessment of side-effects would be a matter for the competent patient, not for the nearest Court of Appeals. Thus, according to its own logic, the incapacity doctrine may require a hearing for virtually every decision about every medication (and other treatments), and additional hearings as each patient's condition changes.

Even if the doctrine is not extended to its logical conclusion, it is clear that a procession of hearings on competency will divert personnel and funds from other state priorities. As this Court has noted, "[t]he State . . . has a genuine interest in allocating priority to the diagnosis and treatment of patients as soon as they are admitted to a hospital rather than to time-consuming procedural minuets." *Parham* v. *J.R.*, *supra*, 442 U.S. at 605. Moreover, as this Court has observed, an increase in hearings necessarily means "that mental health professionals will be diverted even more from the treatment of patients in order to travel to and participate in—and wait for—what could be hundreds—or even thousands—of hearings each year. Obviously, the cost of these procedures would come from the public monies the legislature intended for mental health care." *Id.* at 606. It is true, now as then, that "[b]ehavioral experts in courtrooms and hearings are of little help to patients." *Ibid.*

More significantly, the need to hold a competency hearing may impede the provision of needed treatment, leading to a worsening of the patient's condition and, ultimately, to a longer period of confinement. Under the decision below, if a committed patient rejects medication the treating psychiatrist has two alternatives: either he can forgo treatment or he can seek a judicial declaration of incapacity.[20] Even if the latter course is followed, medication will be restricted at least until the hearing is completed. This hiatus in treatment will often occur at the beginning of a commitment, when the pa-

---

[20] In an "emergency," less rigorous procedures apparently would suffice. See n.4 *supra*. If the emergency exception is read broadly, and the procedures required in such circumstances are easy to satisfy, it may well be that the emergency provision will obviate the need for judicial hearings, thus effectively blunting much of the impact of the court's decision. More likely, a staff psychiatrist, concerned about potential damages actions, see *Romeo* v. *Youngberg*, 644 F.2d 147 (3rd Cir. 1980), *cert. granted*, 49 U.S.L.W. 3851 (May 18, 1981), will hesitate before invoking the emergency route.

tient's illness is likely to be most acute. At that point, delay may have particularly serious consequences, leading to the deterioration of an illness that might have been treated quickly and effectively. As the Court of Appeals itself acknowledged, "[t]he *failure* to medicate an incompetent patient could have side effects—e.g., the unnecessary and possibly irreversible continuation of his illness—far more harmful, and probable, than any that might result from the drugs themselves." 634 F. 2d at 660 (emphasis in original).[21] See also Gutheil, et al., *Legal Guardianship in Drug Refusal: An Illusory Solution*, 137 Amer. J. Psychiat. 347 (1980).[22]

Such costs might be justifiable, indeed desirable, if there had been no prior hearing on the issue of mental illness (as was held before commitment) or if the hearings provided some substantial protection not available through proper exercise of professional discretion.[23] But

---

[21] The Court did not explain why the same conclusion would not apply to a "competent" civilly committed patient.

[22] These concerns are not fanciful. An article reviewing the effects of the temporary restraining order entered by the district court in this case found that there had been a significant decline in the quality of patient care as a result. See Stone, *Mental Health Litigation: A Critical Perspective*, 134 Amer. J. Psychiat. 273, 278 (1977). Similarly, a recent study of the effects of *Rennie* v. *Klein*, *supra*, a New Jersey case declaring a right to refuse medication, indicated that the decision had caused lengthy treatment delays and substantial procedural costs. See Perr, *Effect of the Rennie Decision on Private Hospitalization in New Jersey: Two Case Reports*, 138 Amer. J. Psychiat. 774 (1981).

[23] In circumstances where it is thought that judicial involvement is necessary or desirable because medication has been systematically abused—which was not the situation in this case, see p. 3, *supra*—we think that a better approach than requiring competency hearings would be to have the committing court review and approve the proposed treatment plan, including the need for medication. After this initial approval, the patient's treatment could be subjected to psychiatric peer review to assure that it is being implemented effectively and that medication is not used for purposes other than treatment. Such a procedural approach, while

that is not the case. Most people who are sufficiently mentally ill to be committed do not maintain any meaningful capacity to make treatment decisions. See, e.g., Grossman and Summers, *A Study of the Capacity of Schizophrenic Patients to Give Informed Consent*, 31 Hosp. & Comm. Psychiat. 205 (1980). Moreover, when a competency hearing is held, the available data indicate that the courts invariably follow the psychiatrists' views, and authorize treatment despite the patients' objections. See, e.g., Morris, *Conservatorship for the "Gravely Disabled": California's Nondeclaration of Nonindependence*, 1 Inter. J. Law & Psychiat. 395 (1978). Thus, while imposing substantial costs, competency hearings typically do little more than place judicial validation on a treatment decision that is essentially clinical.[24]

It may be argued that these costs are still justified when respect for *any* individual's autonomy hangs in the balance. But the autonomy at stake here is, in many ways, more conceptual than real. The process of commitment itself has limited the patient's autonomy in the interest of providing treatment for his mental illness, as well as a measure of protection for himself or others.

---

requiring judicial scrutiny and ongoing assurances against misuse of medication, has none of the costly and counterproductive consequences of relying on competency determinations.

[24] This Court has previously stated:

> "[W]e do not accept the notion that the shortcomings of specialists can always be avoided by shifting the decision from a trained specialist using the traditional tools of medical science to an untrained judge or administrative hearing officer after a judicial-type hearing. Even after a hearing, the nonspecialist decisionmaker must make a medical-psychiatric decision. Common human experience and scholarly opinions suggest that the supposed protections of an adversary proceeding to determine the appropriateness of medical decisions for the commitment and treatment of mental and emotional illness may well be more illustory than real." *Parham* v. *J.R.*, *supra*, 442 U.S. at 609.

It makes little sense then to resurrect that autonomy in a fashion that frustrates the beneficial purpose for which it was limited in the first place. The plain fact is that "[i]f it is unconstitutional to treat competent . . . patients, it is irrational to confine them in hospitals." Stone, *The Right to Refuse Treatment*, *supra*, 38 Arch. Gen. Psychiat. at 361.

For these reasons, the APA believes that the decision to commit should not be unhinged from the decision to treat. If civil commitment is to be anything other than a system of benign or preventive confinement, the state must be able to treat the illness that is the basis of commitment itself. The decision below is an unwarranted interference with that legitimate interest.[25]

---

[25] Even if, contrary to our position, this Court should rule that a committed patient cannot be medicated involuntarily unless he lacks the capacity to make the decision himself, we think that under the principles established in *Parham* v. *J.R.*, *supra*, the psychiatrist, rather than a court, should be authorized to make the determination of incapacity. In *Parham*, which involved civil commitment of children, the Court made clear that "[d]ue process has never been thought to require that the neutral and detached trier of fact be law-trained or a judicial or administrative officer . . . Surely, this is the case as to medical decisions for 'neither judges nor administrative hearing officers are better qualified than psychiatrists to render psychiatric judgments.'" 442 U.S. at 607, quoting *In re Roger S.*, 19 Cal. 3d 921, 941, 569 P.2d 1286, 1299 (1977) (Clark, J., dissenting). Accordingly, the Court concluded, due process is satisfied when the decision to hospitalize the objecting child is made by "a staff physician . . . so long as he or she is free to evaluate independently the child's mental and emotional condition and need for treatment." 442 U.S. at 607. The issue to be decided here—day-to-day capacity to consent to medication—involves precisely the same kind of clinical determination. Moreover, since such determinations should be made repeatedly, see pp. 22-23, *supra*, there is even more reason to have the treating psychiatrist make them. Cf. *Rennie* v. *Klein*, 476 F. Supp. 1294, 1314 (D.N.J. 1979) (staff psychiatrist to evaluate competence to consent to medication).

## CONCLUSION

The decision of the Court of Appeals should be reversed.

Respectfully submitted,

JOEL I. KLEIN *
H. BARTOW FARR, III
ONEK, KLEIN & FARR
2550 M Street, N.W.
Washington, D.C. 20037
202-775-0184

* Counsel of Record